STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395909	A. BLDG: 00 B. WING:	03/10/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DARWAY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **040102**	**5865 ROUTE 154** **FORKSVILLE, PA 18616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification Survey, State Licensure Survey, and Civil Rights Compliance Survey, completed on March 10, 2023, it was determined that Darway Healthcare and Rehabilitation Center was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0558 SS=D		F 0558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0558 SS=D	Continued from page 1 483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 0558	1. Resident 41's call bell clip was immediately replaced and call bell placed in reach. Resident 6 bed control remote was immediately placed within residents reach. 2. The facility will complete a whole house audit to ensure proper call bell placement for residents, call bells have a clip attached and bed remotes are within reach while residents are in bed. 3. Education will be provided to facility staff to ensure call bells are properly placed for residents and bed remotes are within reach. 4. IDT will complete an audit for proper call bell placement and bed remotes within reach daily x 5 and then biweekly x 3. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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F 0558 SS=D	Continued from page 2 	F 0558		
F 0582 SS=D	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid	F 0582	1. Cannot be retroactively corrected. 2. The facility will complete an audit of NOMNC notices given within the last 30 days to ensure they are signed or mailed to responsible party. 3. Education will be given to the social service director and her backup, the ADON on ensuring NOMNC notices are mailed when verbal consent is given and mailing is documented in the electronic chart. 4. IDT will complete an audit of NOMNC notices weekly x 4 to ensure proper notification and mailing process. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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F 0582 SS=D	Continued from page 3 State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by:	F 0582		

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F 0582 SS=D	Continued from page 4 Based on clinical record review and staff interview, it was determined that the facility failed to provide required notification to a resident whose payment coverage changed for one of four residents reviewed (Resident 37). Findings include: A review of the form "Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123," (a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization (QIO) to appeal) revealed instructions that a Medicare provider must ensure that the notice is delivered at least two calendar days before Medicare covered services end. The provider must ensure that the beneficiary or their representative signs and dates the NOMNC to demonstrate that the beneficiary or their representative received the notice and understands the termination of services can be disputed. If the provider is personally unable to deliver a NOMNC to a person acting on behalf	F 0582		

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F 0582 SS=D	Continued from page 5 of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. Confirm the telephone contact by written notice mailed on that same date. A review of the "Form Instructions Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055" revealed that examples of the common reasons why an extended care stay, or services may not be covered under Medicare might include the beneficiary no longer requires daily skilled care for a medical condition but wants to continue residing in the skilled nursing facility (SNF). The SNF enters a good faith estimate of the cost of the corresponding care that may not be covered by Medicare. In the blank that follows "Beginning on ...," the skilled nursing facility enters the date on which the beneficiary may be responsible for paying for care that Medicare is not expected to cover. The beneficiary selects an option box to indicate a desire to continue to receive the care or not to continue to	F 0582		

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F 0582 SS=D	Continued from page 6 receive the care and if there is a desire to have the bill submitted to Medicare for consideration. The beneficiary or their authorized representative must sign the signature box to acknowledge that they read and understood the notice. The SNF must issue this notice when there is a termination of all Medicare Part A services for coverage reasons. If after issuing the NOMNC, the SNF expects the beneficiary to remain in the facility in a non-covered stay, the SNFABN must be issued to inform the beneficiary of potential liability for the non-covered stay. Clinical record review for Resident 37 revealed social services documentation dated February 14, 2023, at 7:46 AM that assessed her with severe cognitive impairment (Brief Interview for Mental Status score of three out of a potential 15), that Resident 37 had two days of wandering behaviors, and one day of verbal and physical behaviors towards staff. The documentation indicated that Resident 37 was expected to stay long-term at the	F 0582		

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F 0582 SS=D	Continued from page 7 facility per her daughter. Census information indicated a change in payment for Resident 37's care on February 18, 2022, when Resident 37 converted to private pay. A review of a CMS-10123 form provided by the facility indicated that Resident 37's last covered day of Medicare services ended February 15, 2023. The document indicated that Employee 1 (social services director) called Resident 37's daughter on February 13, 2023, to explain the planned notice of non-coverage and Resident 37's appeal rights because Resident 37 could not sign/understand the document due to her cognitive impairment. The document did not include a dated signature of Resident 37's responsible party (daughter). The document did not indicate that the facility mailed the notice to Resident 37's responsible party. Review of a CMS-10055 form provided by the facility indicated that beginning on February 16, 2023, Resident 37 may have to pay out of pocket	F 0582		

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F 0582 SS=D	Continued from page 8 for care. A handwritten note at the bottom of the form indicated that Resident 37's responsible party/daughter gave, "verbal consent," on February 13, 2023. The document did not include a dated signature from Resident 37's responsible party. Interview with Employee 1 (social services director) on March 10, 2023, at 10:27 AM, confirmed that the facility did not mail the above notices to Resident 37's daughter/responsible party. 483.10(g)(17)(18)(i)-(v) Medicaid/medicare Coverage/liability Notice Previously cited deficiency 03/21/22 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0582		
F 0584 SS=E		F 0584		

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F 0584 SS=E	Continued from page 9 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Facility addressed the environmental concerns listed on the 2567. 2. The facility will complete a resident room and resident common areas audit to identify and address any environmental issues. 3. Education will be given to facility staff to report any environmental concerns observed in resident areas. 4. Random audit of resident rooms and resident common areas will be completed for environmental concerns weekly x 4. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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F 0584 SS=E	Continued from page 10 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=E	Continued from page 11 Based on observation and resident and staff interview, it was determined that the facility failed to provide a clean, homelike environment on one of one nursing units (Residents 36, 30, 6, and 35, and activities room, patio, and sitting area). Findings include: An observation on March 7, 2023, at 11:44 AM of Resident 36's room revealed heating units along the window side wall of the room. Peeling and chipped paint was observed covering the heating units. The bathroom interior and exterior door frame was significantly marred, deep gouges were observed in the exposed wood with some splintering. The concrete wall between the bathroom and closet contained chipped paint and concrete. Ceiling tiles above the entry/exit door of the room and corner of the room on the window side contained several ceiling tiles with brown stains. An observation of Resident 30's room on March 7, 2023, at 12:07 PM revealed peeling paint and	F 0584		

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F 0584 SS=E	Continued from page 12 significantly marred and gauged bathroom door frame on the exterior and interior of the door frame. Dirt and debris buildup was observed along cove base of the wall near the bathroom, and behind the door to the room. An observation of unoccupied resident room 110, which was available and ready for residents to reside in, revealed significant marring and peeled paint on the interior and exterior bathroom door frame. A concrete wall between the bathroom door frame and closets had marring and peeled paint, which also extended on the frames of three closets located in the room. The environmental concerns identified in the rooms of Resident 36, 30, and room 110, were reviewed with the Nursing Home Administrator and Director of Nursing on March 8, 2023, at 2:30 PM. An observation on March 7, 2023, at 11:48 AM revealed a large brown stain on a ceiling tile above a bookshelf in the activities room.	F 0584		

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F 0584 SS=E	Continued from page 13 An observation on March 8, 2023, at 10:14 AM of a patio area next to the main nurse's station revealed several areas of chipped paint on the walls. A protective metal radiator cover had a broken (missing) and jagged section that was six inches by three inches in size. The tile on top of the protective radiator cover was broken and jagged with the wood showing underneath. The floor at the perimeter where it met the walls had a significant accumulation of debris that included dirt and pieces of a cookie. An observation on March 8, 2023, at 10:20 AM revealed a resident sitting area next to the main nurse's station. A cloth chair was observed that had a significant amount of torn black fabric visible coming from underneath the chair. An observation on March 8, 2023, at 12:21 PM revealed an electric fireplace that was on in the main lobby of the facility. The upper right corner of the protective cover was loose and coming away from	F 0584		

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F 0584 SS=E	Continued from page 14 the framing of the fireplace. There was a piece of crumbled tissue observed on the bottom of the fireplace inside of the protective covering. The top of the mantle over the fireplace had a significant build-up of dust and debris that also included a large amount of glitter. Observation of Resident 6's bedside table on March 9, 2023, at 8:55 AM revealed a chipped and damaged edge in several locations. The environmental concerns identified in Resident 6's room, the activities room, patio, and sitting area were reviewed with the Nursing Home Administrator and Director of Nursing on March 8, 2023, at 2:15 PM. The bedside table was discussed with the Director of Nursing on March 10, 2023, at 10:15 AM. Observation of Resident 35's room on March 8, 2023, at 9:57 AM revealed an overbed table on which Resident 35's television was positioned. A large portion (approximately greater than eight	F 0584		

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F 0584 SS=E	Continued from page 15 inches by four inches) of the overbed table's laminate was peeled off, exposing a porous surface. The edges of the remaining laminate presented as lifted, sharp, edges. Resident 35, on the date and time of the interview, directed the surveyor's attention to her second overbed table (used for meal trays and personal items), which had at least three areas of missing and peeling laminate (approximately one-half inch, one inch, and greater than two inches) along the edge of the table. The edges of the remaining peeling laminate presented as lifted, sharp, edges. There also was a box of Resident 35's ostomy supplies (e.g., pouches secured to the abdomen via adhesive dressings used to collect stool excreted from a surgically made abdominal opening) stored directly on the floor at the foot of her bed. The surveyor reviewed the above concerns regarding Resident 35's environment during an interview with the Nursing Home Administrator and the Director of Nursing on March 8, 2023, at 2:05 PM.	F 0584		

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F 0584 SS=E	Continued from page 16 28 Pa. Code 207.2(a) Administrators responsibility	F 0584		
F 0686 SS=E		F 0686		

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F 0686 SS=E	Continued from page 17 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	1. Resident 6 heel boots were added to the Kardex and the order was clarified. Resident 15 order was clarified through the wound consultant and updated. 2. The facility staff will complete an audit of heel boot orders to ensure Kardex placement. The facility will also audit wound orders to ensure they match the wound care recommendations. Facility will audit wound care treatments to ensure orders are followed. 3. Education will be given to licensed staff on ensuring treatment orders are following for wound care and heel boot orders are placed on the Kardex. Education will also be given on proper procedure of signing and dating of dressings. 4. Audits of heel boots orders placed on Kardex and heel boots in place will be conducted bi weekly x 4. Audit of wound care treatments will be completed weekly x 4. Audit of new wound care orders will be	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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F 0686 SS=E	Continued from page 18	F 0686	completed for accuracy weekly x 4. Findings will be reported to QAPI team for any further follow up and recommendations	

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F 0686 SS=E	Continued from page 19 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to provide the highest practical care to promote pressure ulcer healing for two of three sampled residents identified with skin issues (Residents 6 and 15). Findings include: Clinical record review for Resident 6 revealed a diagnoses list that included pressure ulcers: left buttocks, right lateral thigh, and right heel. A current care plan for Resident 6 indicated actual skin breakdown related to pressure ulcers and an intervention noted indicated to administer treatment per physician orders. Clinical record review for Resident 6 revealed a nursing note dated March 4, 2023, at 9:55 AM that revealed the right lateral thigh and heel remain the same; the right thigh measured 4.0 x 0.8 x 0.5 centimeters (cm) with moderate serous drainage	F 0686		

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F 0686 SS=E	Continued from page 20 (pale yellow or transparent colored drainage). The right heel was epithelialized (a type of tissue that forms over a healing wound). Treatment continues as ordered. A current physician's order for Resident 6 dated January 25, 2023, instructed staff to apply Santyl external ointment (an ointment to help heal pressure ulcers) 250 units per gram (units/gm) daily to the right lateral thigh topically for a Stage IV (full thickness skin loss with exposed bone, tendon, or muscle) pressure area; cleanse the right thigh open area with normal saline (a solution that can be used to irrigate and clean wounds); pat dry; apply Santyl to the slough area (area of dead skin) only; fill the remaining wound bed with quarter-strength Dakin's (skin wound cleanser) moistened gauze; and to cover with a bordered foam dressing and change daily. Another current physician's order for Resident 6 revealed a wound consult evaluation and treat as necessary.	F 0686		

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F 0686 SS=E	Continued from page 21 Wound consultation documentation dated January 19 and 26, 2023, and February 2, 16, and 27, 2023, also revealed a Stage IV pressure ulcer/injury to the right lateral thigh. The plan of care noted for each consult instructed to "Cleanse site with normal saline only!" Observation of wound care treatment for Resident 6 with Employee 2, registered nurse, visually confirmed the resident had a pressure sore to the right lateral thigh. Employee 2 proceeded to cleanse the wound with a sterile water-soaked gauze pad and not normal saline as directed by the current physician order and wound consultation documentation. Further observation of Resident 6's wound care revealed Employee 2 completed the dressing change and then proceeded to write (the current date, her initials, and time) with a black-colored pen directly on the dressing that was just applied to Resident 6's right lateral thigh instead of doing so prior to the	F 0686		

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F 0686 SS=E	Continued from page 22 dressing being applied. Resident 6's current care plan indicated actual skin breakdown related to pressure ulcers and an intervention noted included to encourage/assist to suspend/float heels as able when in bed. The care plan indicated this also showed on the Kardex (an electronic device that includes pertinent resident information used for care). Wound consultation documentation dated January 26, 2023, and February 2, 16, and 27, 2023, indicated a plan of care that included to "offload heels while in bed." Clinical record review of the tasks for Resident 6 revealed a current task dated January 18, 2023, that indicated "Device - Application boots to bilateral heels every shift." A review of the past 30 days revealed no documented evidence that the heel boots were being applied and noted "No Data Found."	F 0686		

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F 0686 SS=E	Continued from page 23 Observation of Resident 6 on March 8, 2023, at 9:15 AM revealed the resident was in bed with no heel protectors on and no evidence of any intervention that the resident's heels were offloaded or suspended or floated to relieve pressure. Two heel boots were observed in the room not in use. Observation of Resident 6 on March 9, 2023, at 8:55 AM revealed the resident was in bed with no heel protectors on and no evidence of any intervention that the resident's heels were offloaded or suspended or floated to relieve pressure. Two heel boots were observed in the room not in use. A concurrent interview with Employee 5, licensed practical nurse, revealed that she was unaware if the resident was to use the heel boots. A review of the Kardex with Employee 5 revealed the heel boots were not listed as an intervention. Observation of Resident 6 on March 9, 2023, at 1:53 PM during wound care, revealed the resident was in bed with no heel protectors on and no evidence of any intervention that the resident's heels	F 0686		

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F 0686 SS=E	Continued from page 24 were offloaded or suspended or floated to relieve pressure. Two heel boots were observed in the room not in use. The above findings for Resident 6 were reviewed in an interview with the Director of Nursing on March 10, 2023, at 9:10 AM. The Director of Nursing stated that it would be an expectation that the heel boots would be used if listed under tasks but would check. A further interview with the Director of Nursing on March 10, 2023, at 9:30 AM confirmed the heel boots were not listed on the Kardex and the Director of Nursing "had staff add the boots to the Kardex." Interview with Resident 15 on March 7, 2023, at 10:07 AM revealed that he has had pressure ulcers, down to the bone, on his butt, for years. Resident 15 stated that he leaves the facility to attend appointments at a wound clinic as well as receives services from a wound consultant in the facility	F 0686		

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F 0686 SS=E	Continued from page 25 weekly. Clinical record review for Resident 15 revealed wound consulting CRNP's (certified registered nurse practitioner's) documentation dated February 2, 16, and 27, 2023, that noted a Stage IV pressure injury of his coccyx (tailbone) that measured 2 cm by 2 cm by 1 cm. The plan for Resident 15's Stage IV pressure injury of the coccyx was to cleanse the wound with one-quarter strength Dakin's (dilute solution of sodium hypochlorite (bleach) and other stabilizing ingredients, traditionally used as an antiseptic, to cleanse wounds in order to prevent infection) solution, apply skin protectant to the area around the wound, apply 0.1 percent gentamicin (antibiotic) to the wound base, gently fill the cavity with gauze moistened with normal sterile saline, and cover with a bordered foam dressing. Review of physician orders active since February 7, 2023, for Resident 15's Stage IV coccyx pressure ulcer treatment, instructed staff to cleanse with normal sterile saline moistened gauze, apply	F 0686		

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F 0686 SS=E	Continued from page 26 gentamicin sulfate ointment 0.1 percent, then cover with bordered foam dressing daily per the wound clinic every day shift. The active physician order did not implement the wound consultant's plan to cleanse the wound with one-quarter strength Dakin's solution or to gently fill the wound cavity with gauze moistened with normal sterile saline before the application of a bordered foam dressing. Observation of Resident 15's pressure ulcer treatment on March 9, 2023, at 1:15 PM with Employee 2 (registered nurse) revealed that the soiled dressings were already removed from Resident 15's coccyx wound before the surveyor's observation. Employee 2 cleansed the coccyx wound with gauze moistened with normal sterile saline. After performing hand hygiene, Employee 2 used a sterile cotton-tipped applicator to apply gentamicin ointment to the coccyx wound base and covered the wound with a bordered foam dressing. Employee 2 did not insert any moistened gauze	F 0686		

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F 0686 SS=E	Continued from page 27 packing to the wound before the application of the bordered foam dressing. Interview with Employee 2 on March 9, 2023, at 2:24 PM confirmed that the active physician's order as written since February 7, 2023, did not instruct the nurse to use moistened gauze packing in Resident 15's coccyx wound despite the plan stipulated in the wound consultant's documentation that listed the intervention on three appointment dates. Interview with the Nursing Home Administrator and the Director of Nursing on March 10, 2023, at 11:12 AM confirmed that Resident 15's physician's orders, and implemented treatments by staff, did not include loosely packing Resident 15's coccyx wound with moistened gauze. The interview indicated that the facility nursing staff were waiting for clarification from the wound care consultants before rewriting all physician orders pertaining to Resident 15's pressure ulcer treatments.	F 0686		

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F 0686 SS=E	Continued from page 28 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.5(h) Clinical records	F 0686		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. Facility addressed the sanitation concerns listed on 2567. 2. The facility will complete a kitchen audit to ensure no further sanitation concerns. 3. Education will be given to dietary staff on sanitation concerns identified and process to report any concerns to dietary management and maintenance as needed. 4. Audit of sanitation of the kitchen areas will be completed weekly x 4. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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F 0812 SS=F	Continued from page 29 Based on observation and staff interview, it was determined that the facility failed to store and prepare food items in a safe and sanitary manner in the facility's main kitchen. Findings include: Observation of the facility's main kitchen with Employee 3, dietary manager, on March 7, 2023, at 9:39 AM revealed the following: Five plastic scoop plates (adaptive feeding plate with raised edges) were observed on a shelf below the food serving line with dried food debris on the plates. The plates were also stained and discolored. The wall behind the coffee maker contained three holes 1 to 2 inches in diameter, dried food/liquid splatter was also observed on several areas of the wall. The exhaust vent covering the stove and cooktop area contained peeling and chipping paint on the	F 0812		

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F 0812 SS=F	Continued from page 30 exterior and interior side of the vent. An open pot of peas and carrots was observed being cooked on the stove top. A small upright freezer located near the exit door to the dining room was observed with a thick buildup of ice and frost on the freezer shelves. A concrete wall and ledge area in the lower basement level storage area, which extended to an outside exit, contained dust/debris and chipped concrete. An inverted stack of disposable meal trays were observed stored directly on the concrete ledge uncovered. A chest freezer labeled number five in the lower-level storage area was observed with debris and a frozen white colored substance on the interior base of the freezer. Frozen food products were stored in plastic milk crates in the freezer, several of the crates appeared dirty. An upright freezer labeled number one contained	F 0812		

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F 0812 SS=F	Continued from page 31 debris in the interior base of the freezer. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 8, 2023, at 2:30 PM. 483.60(i)(1)(2) Food Procurement, Store/Prepare/Serve-Sanitary Previously cited 3/21/22 28 Pa. Code 211.6 (c)(d) Dietary services	F 0812		
F 0880 SS=D		F 0880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0880 SS=D	Continued from page 32 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. Cannot be retroactively corrected. 2. The facility will complete an audit to ensure all visitors are mask complaint during a Covid outbreak and/or when the facility is in a high county transmission rate status. 3. Education will be given to facility staff regarding mask compliance for visitors during a Covid outbreak and/or when the facility is in a high county transmission rate status. If visitor is unable or unwilling to wear a mask, other accommodations will be made. 4. Audit of visitor mask compliance will be completed bi weekly x 4. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395909	A. BLDG: __00_____ B. WING: _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0880 SS=D	Continued from page 33 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=D	Continued from page 34	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 35 Based on review of select facility policy and procedures, observation, staff and family interview, and infection control surveillance documentation, it was determined that the facility failed to implement source control to prevent the spread of COVID-19 among visitors to residents (Resident 49). Findings include: The facility's current policy entitled SARS-CoV-2 Management," revealed the facility staff will educate residents and families on the actions the facility is taking to protect them and their loved ones from COVID-19, and actions they should take to protect themselves and others in the facility, emphasizing when they should wear source control (i.e., masks), and physically distance. In an entrance interview with the Nursing Home Administrator (NHA) and Director of Nursing on March 7, 2023, at 10:34 AM the NHA indicated the facility was in outbreak status for COVID-19, with two COVID positive residents currently in	F 0880		

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F 0880 SS=D	Continued from page 36 isolation. The NHA also indicated facility staff were required to wear a surgical mask and eye protection in the facility, and additional personal protective equipment was required for the COVID isolation rooms including a gown, gloves, and N95 mask. Review of the CMS QSO-20-39-NH revised on September 23, 2022, indicated that residents must be allowed to receive visitors as he/she chooses. The core principles consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, should be adhered to at all times. These core principles include a face covering or mask (covering mouth and nose in accordance with CDC guidance). If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention.	F 0880		

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F 0880 SS=D	Continued from page 37 If resident representatives would like to have a visit during an outbreak, they should wear face coverings or masks during visits and visits should ideally occur in the resident room. While an outbreak is occurring, facilities should limit visitor movement in the facility. An observation on March 7, 2023, at 12:05 PM revealed Resident 49 was in a COVID-19 isolation room, and the resident was one of two COVID positive residents in isolation in the facility. Clinical record review for Resident 49 revealed the resident tested positive for COVID-19 on February 26, 2023. In a telephone interview with Resident 49's responsible party (RP) on March 8, 2023, at 10:38 AM the RP indicated she was aware of Resident 49 being COVID positive, and the facility made her aware of other COVID-19 cases in the facility. Resident 49's RP stated she visits the facility at least weekly.	F 0880		

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F 0880 SS=D	Continued from page 38 An observation on March 8, 2023, at 12:46 PM revealed Resident 49 was removed from isolation and placed back in her original room. An observation on March 9, 2023, at 11:00 AM revealed a visitor walking out of the activity room, where several residents were participating in an activity, without a mask or face covering. The visitor proceeded to walk down the hallway to an additional hallway and into the room where Resident 49 now resided, passing several additional residents who were sitting or walking in the hallways along the way. The visitor was observed placing some items on Resident 49's stand and then exiting the room. Resident 49 was not present in the room. Concurrently, the visitor was observed walking down the hallway with the NHA, again without a mask or facial covering to locate the surveyor with whom she completed a phone interview with the day prior. The visitor was identified as the RP for Resident 49 who had indicated she was visiting Resident 49 as the resident was completing an activity in the activity room. The RP then exited the	F 0880		

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F 0880 SS=D	Continued from page 39 facility. In a concurrent interview with the NHA, the NHA indicated the facility staff encourage visitors to wear source control, but do not prevent visitation of they do not comply. During the above observation of Resident 49's RP, no staff were observed asking the visitor to don a mask for source control of COVID-19, as the RP was in the activity room with other residents and walking the hallways where other residents were present without source control. Facility staff failed to instruct the RP that if source control was not worn with the recommended guidance as the facility was in outbreak status for COVID-19, the RP could only visit with the resident in the resident's room without roommates present or a designated area where only the RP and resident could visit, to prevent the potential spread of infection to the high risk population of other residents residing in the facility.	F 0880		

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F 0880 SS=D	Continued from page 40 The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 9, 2023, at 2:00 PM. 483.80 (a)(1) Infection Prevention & Control Previously cited 3/21/22 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing care services	F 0880		

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P 0400	§ 201.14(a) Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION is not met as evidenced by:	P 0400	1. Cannot be retroactively corrected. 2. Audit of past 6 months of Infection control meeting signatures will be completed. 3. Education to infection control representative and infection control preventionist on requirement for attendance of quarterly meetings. 4. Audit of quarterly infection control meetings to ensure infection control representative attendance and signature quarterly x 2. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 0400	Continued from page 1 Based on staff interview and documentation review, it was determined that the facility did not comply with the requirements of the Act 52 Infection Control Plan. Findings include: The Act 52 Infection Control Plan, states that a health care facility should develop and implement an internal infection control plan that should be established for improving the health and safety of residents and health care workers and should include a multidisciplinary committee including a representative from each of the following, if applicable, to the specific health care facility: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel (iv) Nursing staff that could include a director of	P 0400		

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P 0400	Continued from page 2 nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A patint safety officer (viii) Members from the infection control team, which could include an epidemiologist. (ix) The community, except that these representatives may not be an agent, employee or contractor of the health care facility. A review of the facility infection control meeting attendance revealed the facility met quarterly for infection control meetings. Further review of the attendance records for the last 12 months revealed the infection control meetings were held April 20, July 29, and October 28, 2022, and January 31, 2023. There was no evidence a pharmacy representative attended any of the meetings. Interview with the Nursing Home Administrator and Director of Nursing on March 9, 2023, at 2:15 PM confirmed that no pharmacy staff attended the	P 0400		

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P 0400	Continued from page 3 facility infection control meetings in the last 12 months.	P 0400		
P 1895	§ 211.9(j) Pharmacy services. (j) Disposition of discontinued and unused medications and medications of discharged or deceased residents shall be handled by facility policy which shall be developed in cooperation with the consultant pharmacist. The method of disposition and quantity of the drugs shall be documented on the respective resident's chart. The disposition procedures shall be done at least quarterly under Commonwealth and Federal statutes. This REGULATION is not met as evidenced by:	P 1895	1. Cannot be retroactively corrected. 2. Audit of discharged residents in past 14 days will be completed to assess disposition of meds completion. 3. Education to licensed staff on the requirement of disposition of meds being included in closed chart. 4. Audit of discharged residents weekly x 4 to ensure disposition of med compliance. Findings will be reported to QAPI team for any further follow up and recommendations.	Completion Date: **04/19/2023** Status: **APPROVED** Date: **03/22/2023**

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P 1895	Continued from page 4 Based on closed clinical record review and staff interview, it was determined that the facility failed to account for the disposition of medications upon discharge for three of three discharged residents reviewed (Residents 55, 53, and 54). Findings include: Closed clinical record review for Resident 55 revealed nursing documentation dated January 1, 2023, at 2:31 PM that Resident 55's wife reported to the nurse's station and requested to take Resident 55 home. Staff advised Resident 55's wife that the discharge would be against medical advice (AMA) per Resident 55's physician. Resident 55's wife agreed to sign the AMA document. The documentation indicated that staff sent, "...all medication ... with and (sic) explanation of medications and times for administration given;" and Resident 55 discharged to home. Resident 55's closed clinical record included medication administration records (MAR, electronic	P 1895		

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P 1895	Continued from page 5 documentation of the administration of medication) dated December 2022 and January 2023 that indicated staff administered the following prescription medications to Resident 55 as per his physician orders: Atorvastatin Calcium (medication used to lower cholesterol) 20 mg (milligrams) at hour of sleep Olanzapine (antipsychotic used to treat agitation with mental/mood disorders) 10 mg at bedtime Protonix (medication used to reduce stomach acid) 40 mg daily Toprol XL (medication used to treat chest pain and lower blood pressure) 25 mg daily Trazodone HCL (antidepressant) 150 mg at hour of sleep Apixaban (medication used to prevent blood clots) 5 mg twice a day Levetiracetam (medication used to prevent seizures) 500 mg twice a day Interview with the Director of Nursing on March 9, 2023, at 12:40 PM revealed that the facility had no	P 1895		

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P 1895	Continued from page 6 evidence of the disposition of Resident 55's medications to include the name and quantity upon discharge. Closed clinical record review for Resident 53 revealed the resident expired at the facility on January 7, 2023. Further review of Resident 53's MAR revealed staff administered the following non-stock medications to the resident up to and including the day the resident expired. Carbamazepine (medication used to prevent seizures) 200 mg one tablet one time a day in the morning, and three tablets at bedtime Clopidogrel Bisulfate (blood thinner) 75 mg daily Duloxetine HCL delayed release sprinkle (antidepressant) 60 mg daily Levothyroxine Sodium (medication used to treat hypothyroidism) 175 micrograms (mcg) daily Pantoprazole Sodium (medication used to treat acid reflux) 40 mg daily Quetiapine Fumarate (antipsychotic medication) 25 mg, one and a half tablets at bedtime	P 1895		

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P 1895	Continued from page 7 Simvastatin (medication used to treat high cholesterol) 80 mg at bedtime Flavoxate HCL (medication to relax the bladder) 100 mg three times a day Gabapentin (medication used to treat pain) 100 mg three times a day Meclizine HCL (medication used to treat dizziness) 25 mg three times a day Methazolamide (medication used to treat glaucoma) 50 mg three times a day There was no evidence to indicate how much of the medication listed above for Resident 53 remained at the time of her death or what was done with remaining the medication. In an interview with the Director of Nursing on March 10, 2023, at 8:45 AM she confirmed there was no record of the disposition of Resident 53's medications upon her death. Closed clinical record review for Resident 54 revealed nursing documentation dated December	P 1895		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
DARWAY HEALTHCARE AND REHABILITATION CENTER STATE LICENSE NUMBER: **040102**	**5865 ROUTE 154 FORKSVILLE, PA 18616**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
P 1895	Continued from page 8 20, 2022, at 10:25 AM that revealed the resident was sent to the hospital due to shortness of breath. A review of the bed hold and transfer notice revealed that Resident 54 declined the bed hold. The resident did not return to the facility and a discharge summary was completed. A review of Resident 54's MAR revealed the resident was receiving the following medications: Lasix 40 milligrams daily (medication used to treat fluid retention) Prednisone 40 mg daily (medication used to treat inflammation) Sulfamethoxazole-Trimethoprim 800-160 mg daily (antibiotic used to treat bacterial infections) Xarelto 20 mg daily (medication used to treat and prevent blood clots) Amiodarone 200 mg two times a day (medication used to treat heart rhythm problems) Metoprolol Tartrate 25 mg two times a day (medication used to treat high blood pressure)	P 1895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395909	A. BLDG: __00_____ B. WING: _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 1895	Continued from page 9 Protonix 40 mg two times a day Albuterol Sulfate inhale two puffs four times a day (medication used for certain lung conditions) Ipratropium Bromide inhale two puffs four times a day (medication used for certain lung problems) There was no evidence to indicate how much of the medication listed above for Resident 54 remained at the time of discharge. Interview with the Director of Nursing on March 9, 2023, at 12:40 PM revealed that the facility had no evidence of the disposition of Resident 54's medications.	P 1895		

Certified End Page

DARWAY HEALTHCARE AND REHABILITATION CENTER

STATE LICENSE NUMBER: 040102

SURVEY EXIT DATE: 03/10/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY